



Communicable Disease and Epidemiology News

Published continuously since 1961

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Vol. 44, No. 4

April 2004

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Measles Among Adoptees From China, April 2004

On April 5th, a toddler recently adopted from China presented to a King County health care provider with a fever and a rash. There was a history of a prodrome, characterized by sore throat, cough, coryza, and conjunctivitis. Koplik's spots were present in the mouth and the child also had otitis media. The health care provider suspected measles and immediately notified Public Health-Seattle & King County (by calling 206-296-4774). Public Health arranged to have the specimen transported to the Washington State Public Health Laboratory the following morning for serologic measles testing. On the afternoon of April 6th, results of testing showed that the child was measles IgM positive, confirming an acute measles infection.

While lab results were pending, an investigation by Public Health revealed that this child and family were part of a group of eleven families, and twelve children adopted from orphanages, who spent approximately 10 days together in China before traveling to the US at the end of March 2004. Of the twelve children in the group, eight came to the Puget Sound area, and one each to Alaska, Florida, Maryland, and New York.

Interviews with the families of the other seven children who came to the Puget Sound area yielded reports of current, or resolved, recent febrile-rash illness in six of these children. Five of these six families had made a total of 14 visits to King County health care providers for their ill children since arriving in the US, seven of these visits were for rash illnesses. Unfortunately, measles had not been considered in the differential diagnosis of any of these children, and measles testing had not been ordered. All six of the ill children have subsequently been confirmed to have had measles.

Sites where persons may have been exposed to these children during their contagious period can be found on the Public Health-Seattle & King County Website at www.metrokc.gov/health. Because a measles outbreak cannot be declared over until two full incubation periods (42 days) have passed since rash onset in the last confirmed case, King County healthcare providers are requested to be vigilant for measles among all persons in the community with compatible symptoms.

Information on Measles Disease

Measles typically begins with a febrile prodrome lasting 2 to 4 days (range 1-7 days). Fever peaks at 103°-105° F, and is followed by the onset of cough, coryza and/or conjunctivitis. One to 2 days prior to the rash, and for 1 to 2 days after rash onset, Koplik's spots may appear as blue-white spots on the bright red background of the buccal mucosa. A maculopapular rash begins first at the hairline, spreading to the face and upper neck. The rash spreads downward on the

body, eventually becoming a full body, generalized rash over the next three days. Other measles symptoms may include anorexia, diarrhea (especially in infants), and generalized lymphadenopathy.

The incubation period for measles is generally 7-18 days, but can be as short as 6 days and as long 21 days. The communicable period is approximately 5 days prior to rash onset, and 4 days after rash onset.

Measles Reporting Requirements

Measles is an immediately notifiable illness. **Health care providers are required to report suspect cases of measles immediately to Public Health at 206-296-4774 (24 hours a day, 7 days a week).** Whenever possible, please contact Public Health while a patient you suspect of having measles is still present in the clinical setting. Public Health can offer assistance with the collection of appropriate specimens for laboratory confirmation of measles, timely routing of specimens to the Washington State Public Health Laboratory, and management of exposures to measles among healthcare workers and other contacts of the patient.

Laboratory Diagnosis

Laboratory criteria for diagnosis includes one of the following:

- Positive serologic test for measles immunoglobulin M (IgM) antibody: requires 4-5 ml blood collected in a red or tiger-top tube (tubes without anticoagulants or preservatives).
- Isolation of measles virus from a clinical specimen: requires urine (preferred), nasal wash, or blood (collected in a heparinized tube).
- Significant (four-fold) rise in measles antibody level between acute and convalescent sera by any standard serologic assay: requires two blood specimens collected as for IgM test, at both the acute and convalescent stage (2 to 3 weeks later) of disease.
Note: This test is not widely available.

Why are International Adoptees at Risk for Measles?

Though any person seeking an immigrant visa to the United States for permanent residency must show proof of having received recommended vaccines before immigration, **internationally adopted children <11 years of age have been exempted from the overseas immunization requirements.** Adoptive parents are required to sign a waiver indicating their intention to comply with the immunization requirements within 30 days after the infant or child's arrival in the United States. Nonetheless, this requirement would not have prevented any of the cases of

measles in the current outbreak because the children were exposed prior to arrival in the United States.

As a result of this outbreak, on April 16, 2004, The Centers for Disease Control and Prevention (CDC) recommended a temporary suspension of adoption proceedings for children from the Zhuzhou Child Welfare Institute in the Hunan Province of China, which is currently experiencing an outbreak of measles.

Adoptive parents (and their families), who go overseas to pick up their child should obtain pre-travel advice, and should ensure that their own immunizations are up-to-date. In addition, health care providers should advise parents adopting children from countries where measles and other vaccine-preventable disease are endemic, to be vigilant for the development of such illnesses during the first 3 weeks after arrival in the US. They should also be advised to avoid extensive community exposures to new adoptees during this time when possible.

The CDC’s Health Information for International Travel (“the yellow book”) contains recommendations pertaining to international adoption, including pre-travel screening, overseas medical examinations, and follow-up medical examination after arriving in the US. It can be found online at: <http://www.cdc.gov/travel/other/adoption.htm>

STD Update and Intensive Course

The Seattle STD/HIV Prevention Training Center and the University of Washington School of Medicine are sponsoring an STD Update and Intensive Course on June 7-9, 2004. The STD Update and Intensive courses provide participants with training in the most recent advancements in the epidemiology, diagnosis, and management of viral and bacterial STDs. The course is designed for health care providers who diagnose and treat patients with sexually transmitted diseases, and will be held at the Seattle STD/HIV prevention Training Center at 901 Boren Ave, Suite 1100.

Applicants with at least six months of STD exam experience have the option of an additional 2-day practicum at the Public Health – Seattle and King County STD Clinic (located at Harborview Medical Center) after completing the didactic course.

The registration fee for the didactic training alone is \$200. Participation in the didactic course plus the 2 day clinic practicum is \$300. To request an application form, call or e-mail Ronnie Staats at 206-685-9848 or rstaats@u.washington.edu.

Foodborne Illness Primer for Physicians and Other Health Care Professionals

It is estimated that 76 million people get sick, more than 300,000 are hospitalized, and 5,000 die as a result of foodborne illnesses annually in the US. To help increase awareness of foodborne illnesses among physicians, nurses and other healthcare providers, a new edition of Diagnosis and Management of Foodborne Illness: A Primer for Physicians and Other Health Care Professionals has been released. The updated primer includes new sections on hepatitis A, noroviruses, antibiotic-resistant salmonella, congenital toxoplasmosis and intentional contamination.

The primer was produced collaboratively by the American Medical Association, the American Nurses Association, the CDC, the Center for Food Safety and Applied Nutrition-Food and Drug Administration, and the Food Safety and Inspection Service of the United States Department of Agriculture. This primer is intended to provide health care professionals with current and accurate information for the diagnosis, treatment and reporting of foodborne illnesses. The primer also provides health care professionals with patient education materials on prevention of foodborne illness. The primer offers Continuing Medical Education credit for physicians, nurses, or health care educators. A PDF version of the primer is at <http://www.ama-assn.org/ama/pub/category/3629.html>

Disease Reporting

AIDS/HIV (206) 296-4645

STDs (206) 731-3954

TB (206) 731-4579

All Other Notifiable Communicable Diseases (24 hours a day) (206) 296-4774

Automated reporting line for conditions not immediately notifiable (206) 296-4782

Hotlines

Communicable Disease (206) 296-4949

HIV/STD (206) 205-STDS

Online Resources

Public Health Home Page: www.metrokc.gov/health/

The **EPI-LOG**: www.metrokc.gov/health/providers

Subscribe to the Public Health Communicable Disease listserv (PHSKC INFO-X) at: <http://mailman.u.washington.edu/mailman/listinfo/phske-info-x>

| Reported Cases of Selected Diseases, Seattle & King County 2004 | | | | |
|--|-------------------------|------|------------------------------|------|
| | Cases Reported in March | | Cases Reported Through March | |
| | 2004 | 2003 | 2004 | 2003 |
| Campylobacteriosis | 17 | 14 | 48 | 48 |
| Cryptosporidiosis | 3 | 5 | 6 | 9 |
| Chlamydial infections | 520 | 442 | 1310 | 1138 |
| Enterohemorrhagic E. coli (non-O157) | 0 | 0 | 0 | 0 |
| E. coli O157: H7 | 0 | 3 | 0 | 9 |
| Giardiasis | 12 | 11 | 35 | 28 |
| Gonorrhea | 104 | 134 | 314 | 359 |
| Haemophilus influenzae (cases <6 years of age) | 1 | 0 | 1 | 0 |
| Hepatitis A | 0 | 5 | 2 | 8 |
| Hepatitis B (acute) | 5 | 2 | 12 | 7 |
| Hepatitis B (chronic) | 80 | 51 | 168 | 153 |
| Hepatitis C (acute) | 2 | 0 | 2 | 2 |
| Hepatitis C (chronic, confirmed/probable) | 146 | 62 | 320 | 287 |
| Hepatitis C (chronic, possible) | 38 | 26 | 92 | 76 |
| Herpes, genital (primary) | 63 | 53 | 177 | 165 |
| HIV and AIDS (includes only AIDS cases not previously reported as HIV) | 54 | 31 | 122 | 115 |
| Measles | 0 | 0 | 0 | 0 |
| Meningococcal Disease | 1 | 1 | 6 | 2 |
| Mumps | 0 | 0 | 0 | 0 |
| Pertussis | 27 | 22 | 71 | 47 |
| Rubella | 0 | 0 | 0 | 0 |
| Rubella, congenital | 0 | 0 | 0 | 0 |
| Salmonellosis | 13 | 18 | 37 | 53 |
| Shigellosis | 4 | 19 | 23 | 35 |
| Syphilis | 8 | 7 | 19 | 20 |
| Syphilis, congenital | 0 | 0 | 0 | 0 |
| OSyphilis, late | 7 | 6 | 22 | 14 |
| Tuberculosis | 12 | 14 | 20 | 24 |

The *Epi-Log* is available in alternate formats upon request.